

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
RELENZA(zanamivir)

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

WRITTEN REQUEST IN LETTER OF MEDICAL NECESSITY

TO 855-828-4992 note the new fax number

CRITERIA:

- Age 7 years old and older
- Diagnosis of Influenza A or Influenza B
- Covered only for patients at high risk from diagnosed and documented disease states if immunodeficiency. The term "immunodeficient" includes: HIV/AIDS or other diseases that affect the immune system; long-term radiation treatment; long-term treatment with drugs such as steroids; oncology agents; immunosuppressive agents or fragility due to extreme age (greater than 65 years).
- Treatment must be started within 72 hours of diagnosis.

INFORMATION:

- Dose: 10mg bid delivered via oral inhaler for 5 days.
- Limit: One box of 20 amps per year